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STATEMENT OF
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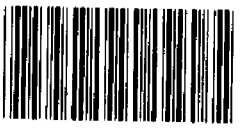
BEFORE THE
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
ON
STATUS OF IMPLEMENTATION OF THE
NATIONAL BLOOD POLICY

Mr. Chairman, we are pleased to be here today to discuss the results of our work concerning (1) implementation of the National Blood Policy and (2) certain improper blood banking practices which have resulted in Medicare program overpayments. We will summarize the findings in our reports on these subjects and the actions taken or promised by the Department of Health, Education, and Welfare (HEW) on our recommendations.

NATIONAL BLOOD POLICY

The National Blood Policy, established by HEW in 1973, called for developing a safe, fast, and efficient blood collection and distribution system; and prescribed specific improvements in blood banking to include: regionalized blood collection and distribution; transition to an all-voluntary blood donation system, and rational alignment



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of charges and costs for blood services. It also stated that if the private sector could not satisfactorily progress toward its implementation, a legislative or regulatory approach would have to be considered.

A plan to implement the National Blood Policy was submitted to the Secretary of HEW in January 1974 by organizations involved in providing blood services. This plan proposed creating an American Blood Commission which was to become largely self-supporting, although grants from private organizations and the Federal Government would be needed initially. The plan suggested establishing 11 task forces to address such matters as blood inventory control and utilization, regional program development, data analysis, and cost control.

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In March 1975, the American Blood Commission was incorporated to carry out the National Blood Policy. The Commission represents many diverse organizations concerned with the National Blood Policy and serves to coordinate planning and develop consensus within all segments of the blood service community regarding ways and means of achieving the policy's goals. Through its first two years of operation the Commission obtained 57 percent of its operating funds from the Federal Government, primarily for operating 5 task force projects.

In our report 1/ concerning our review of the implementation of the policy, we noted several factors which we believed hindered the Commission in carrying out the policy. They were:

--Difficulty in obtaining funds to support its operations.

--Disagreement between the two largest blood suppliers--the American National Red Cross and the American Association of Blood Banks.

--Possible opposition to regionalization of blood collection and distribution, especially from areas in which there are multiple suppliers of blood.

--Possible problems in obtaining data voluntarily from blood banks for use by the National Blood Data Center.

--Lay members' lack of sufficient knowledge of blood banking.

According to an HEW report which outlines the National Blood Policy, the Federal Government will be active in regulation, research, maintenance of needed data and information systems, and development of the relationships between costs and charges for blood services. The HEW report noted that rational alignment of costs and charges

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1/Report to the Secretary of HEW, Problems In Carrying Out the National Blood Policy (HRD-77-150) March 7, 1978.

for blood services is one of the prominent improvements needed in blood banking to achieve the goals of the National Blood Policy. HEW's strategy for implementing the policy stated that the Social Security Administration would develop cost and charge data. Officials of the Health Care Financing Administration which now has this responsibility told us during our review that they were unaware of such a provision in the implementing strategy and had not been asked to fulfill it.

We recommended that the Secretary of HEW closely monitor the Commission's progress in implementing the National Blood Policy and, if not satisfied with this progress, consider a legislative or regulatory approach to implementing the policy. We also recommended that the Secretary instruct the Administrator of the Health Care Financing Administration to determine whether its auditing and accounting procedures can be used to develop the data necessary to show the relationships between costs of and charges for blood services, and to report to the Secretary within 6 months from the date of our report. In responding to a draft of our report, on November 18, 1977, HEW said that an evaluation of the Commission should be feasible within the next year and that the Health Care Financing Administration would report to the Secretary as expeditiously as possible on the relationship between costs and charges for blood services.

In October 2, 1978, letters to us and to certain Congressional committees, HEW said it had no further comments to make on our report and that its response of the previous November remained timely and valid. To our knowledge no evaluation of the American Blood Commission has yet been made by HEW, nor has the Administrator of the Health Care Financing Administration reported to the Secretary of HEW on the relationship between costs and charges for blood services.

MEDICARE OVERPAYMENTS FOR BLOOD CHARGES

The second report we wish to discuss today concerns a recently completed review of Medicare payments for blood products. Our report entitled "Actions Needed to Stop Excess Medicare Payments for Blood and Blood Products (HRD-78-172)" was issued to the Congress on February 26, 1979. The report describes certain practices followed by blood banks and hospitals which have resulted in excess charges to the Medicare program.

Medicare insurance covers many health care services including blood and blood products. It reimburses hospitals for fees charged by blood banks for blood processing. Many blood banks also charge a nonreplacement fee when blood used by a patient is not replaced or donated on a patient's behalf. Through either predeposit programs or direct replacement, an individual earns blood credits which can be used to offset nonreplacement fee charges.

Where nonreplacement fees are charged, the Medicare patient is responsible for replacing the first three units of blood received in a benefit period. If replacement is not made the patient must pay the nonreplacement fee. Medicare assumes responsibility for paying nonreplacement fees beginning with the fourth unit of blood received. It is these nonreplacement fee charges to Medicare that are the subject of our report.

Our review showed that the general practice of the blood banks we visited was to avoid recognizing blood replacement credits for any blood used by Medicare patients when the Medicare program would pay the nonreplacement fees. Thus, for the first three units, which were the patient's responsibility, the blood bank would reduce or eliminate nonreplacement fees to the extent replacement was made. However, for those remaining units of blood for which Medicare assumed reponsibility, the blood banks gave no consideration to whether additional replacement credits were available, but rather passed on the entire nonreplacement fee for Medicare reimbursement.

Blood bank officials told us that their replacement policies were based on their understanding of Medicare requirements and that such practices were common among blood banks and had been in effect for several years. Although Medicare instructions do not specifically state that replacement credits are to be considered when charging

Medicare for nonreplacement fees, Medicare legislation and regulations require equal treatment for Medicare and non-Medicare patients.

Our estimate of the nationwide impact of such practices was limited by the lack of data on replacement credits available to Medicare patients. In 1977, Medicare paid nearly $18 million in nonreplacement fee charges. Information is not available, however, to determine the extent to which such fees could have been reduced through the proper application of replacement credits. Based on the limited information we were able to obtain during our review, we estimated that excess payments by Medicare could total several million dollars annually.

Intermediaries we visited that were responsible for administering the Medicare program were generally unaware of the blood banks' practices or the impact they had on Medicare payments. The intermediaries' monitoring procedures generally ignored these issues. We also learned that the Health Care Financing Administration had been made aware, through certain regional office activities, of problems similar to those discussed in our report. However, needed improvements in billing instructions and program monitoring activities were not made.

We made several recommendations to the Secretary of HEW regarding the need to clarify its billing instructions concerning nonreplacement fees; seek recovery action from

organizations that had engaged in improper practices; develop working agreements between blood banks and hospitals to assure compliance with Medicare instructions; and improve intermediary monitoring procedures. HEW generally concurred with our recommendations, but commented that the most comprehensive response to the problems would be remedial legislation. HEW did not elaborate on legislative changes it considered necessary. HEW noted, however, that pending enactment of legislation, it had identified other more immediate actions it would take to address specific problems we had cited.

We believe that the actions HEW identified would help to alleviate the problems we identified. We are concerned, however, that HEW is not acting to resolve these matters quickly. For example, we wrote to the Health Care Financing Administration on December 12, 1977 while our review was in process alerting it to what we believed were questionable practices regarding blood charges. In its February 1, 1978, letter to us, the Health Care Financing Administration acknowledged that the practices we described were improper, and cited corrective actions that could be taken. In response to our draft report, HEW, on January 19, 1979, identified certain actions it planned to take but did not indicate that any action had been taken.

We noted in our report that, while longer term actions such as studies and regulation revisions were being undertaken, HEW should notify providers as soon as possible,

through some interim communication, that replacement credit practices we found are contrary to Medicare policy and should be stopped. To our knowledge, no final action has been taken on our recommendations. We understand, however, that a letter to Medicare intermediaries is expected to be issued within the next few months which will discuss the issues identified in our report.

This completes our prepared statement. We would be happy to answer any questions you or other members of the Subcommittee may have.